Crisis Counseling Assistance and Training Program
Immediate Services Program
Pilot Application Signature Sheet

State Disaster Mental Health Coordinator. The following individual is the primary contact person for coordinating the mental health response to this disaster. This person will also be the state coordinator for the application process for Federal funds to provide disaster-related mental health services.

Contact person:
Title:
Agency:
Address:
Phone:
Fax:
E-mail address:

_____

***Signature,* Director, State Mental Health Authority**

Name: Phone number:
Fax: E-mail address:

This application represents the Governor's agreement and/or certification:

1. That the requirements are beyond the State and local governments' capabilities;
2. That the program, if approved, will be implemented according to the plan contained in the application approved by the FEMA Disaster Recovery Manager (DRM);
3. To maintain close coordination with and provide reports to the FEMA Regional Director or the Disaster Recovery Manager as the delegate of the Regional Director; and
4. To include mental health disaster planing in the State's emergency plan prepared under title II of the Stafford Act.

The State requests $_____ for Immediate Services:

_____

Signature, Governor's Authorized Representative

Name: Phone Number:
Fax: E-mail address:

(Attach the SF-424 Request for Federal Assistance to the signature sheet.)

FEMA Disaster Number. Enter the FEMA Disaster declaration number below.

[Insert Text]

Part I: Geographic Areas and Initial Needs Assessment

A. Geographic Areas and Estimated Need. In the table provided below, list the areas within the Presidentially-declared disaster area for which services will be provided and the number of people to be served in each area. List the geographic areas to be served in the left hand column. Areas to be served may be listed by service area, county, or other geographic or organizational designation identified by the State. All areas on the list must be with the disaster area declared by the President to be eligible for individual assistance. The service areas designated below will form the basis of the program plan and budget and therefore should be consistent throughout the application. In the right hand column, list the estimated number of people to be served in each area based on the CMHS Damage Assessment Formula, which is provided on the next page. For additional information on completing this section, see page 6 of the supplemental instructions.

[Insert text in table below. Insert additional rows or delete rows as necessary]

Designated Area	Estimated Number to be Served
TOTAL	

B. Needs Assessment Formula. Using the CMHS Needs Assessment Formula (located below) estimate the number of persons you will serve in each designated area (second column of the following table). Attach a CMHS Needs Assessment Formula sheet for each designated area. See the supplemental guidance (pages 7-10) for additional information on completing the CMHS Needs Assessment Formula.

CMHS Needs Assessment Formula for
Estimating Disaster Mental Health Needs Disaster: FEMA XXXX-DR-State

This is an estimate for the following disaster area_____

Date of Report:_____ Completed by:_____

Loss Categories	**Number of Persons**	**ANH**	**Range Estimated**	**Total**
Type of Loss	Number	Multiply by ANH[1]	At-Risk Multiplier	Number of persons targeted per loss category
Dead			100%	
Hospitalized			35%	
Non-hospitalized Injured			15%	
Homes destroyed			100%	
Homes "Major Damage"			35%	
Homes "Minor Damage"			15%	
Disaster Unemployed			15%	
(Others--Specify)				
Total estimated persons in need of crisis Counseling services (add total column)				

Revised June, 2000

[1]ANH means **A**verage **N**umber of persons per **H**ousehold. This figure can be obtained on a county/parish/area basis from the Census Bureau. If the State is unable to determine the ANH for an area, then use the average figure of 2.5.

C. Description of Crisis Counseling Needs and Special Circumstances. Please provide a description of crisis counseling needs within the impacted areas. Describe any special circumstances not captured in the CMHS Needs Assessment Formula that will impact the need for crisis counseling services. For each identified service area, please identify any high risk groups or populations of special concerns identified through the State's initial needs assessment process (e.g. children, adolescents, older adults, ethnic and cultural groups, lower income populations). For additional tips on completing this section, see supplemental instructions, pages 10-11.

[Insert Text]

Part II. State and Local Resources and Capabilities

Very briefly describe the State and local mental health systems. Explain why these resources cannot meet the disaster related mental health needs. For additional information on completing this section see page 12 of the supplemental guidance.

[Insert Text]

Part III. Response Activities from Date of Incident

Provide a description of State and local crisis counseling activities from the date of the incident to the date of application submission. Provide specific number or estimate of disaster victims who have received services up to the date of the application. To the extent possible, activities should be described for each service area listed in Part I of this application. If no activities have been conducted to date, this should be stated as well. Any activities from the date of incident for which the State is requesting financial reimbursement from FEMA must be described in this section. (For additional information on completing this section, see page 13 of the supplemental instructions.)

[Insert Text]

Part IV. Plan of Services

A. Service Providers. In the table provided below, provide a list of the service providers included in this project. In the left hand column, provide the name of the service provider along with the address and contact information for the agency. In the center column, list the service area(s) to be covered by the service provider. Service areas should correspond to areas listed in Part I of this application. In the right hand column, provide the name of the crisis counseling project manager along with contact information. If the project manager has not been identified, provide the name of the agency director and indicate that the project manager has not yet been identified. For additional information on completing this section, see pages 14-15 of the supplemental instructions.

[Insert text in table below. Insert additional rows or delete rows as necessary]

Agency	Service Areas	Crisis Counseling Project Manager
Name Address Phone Fax Director's Name	Cite geographic or organizational designation	Name Address Phone Fax

B. Staffing Plan. In the table below, provide a list of staff positions for which the State is requesting funding through the Immediate Services grant. Staff whose services will be provided to the project as an in-kind contribution from the State or the service provider should also be included in this chart with the words "In-kind" in parenthesis next to the position. In-kind positions should be listed below those funded through the grant and should be clearly distinguished in the totals. This information must be provided for the State and for each service provider. In the left hand column list the name of the service provider. In the second column, list the number of supervisors or team leaders and the percentage of time dedicated to the project. In the third column, list the number of outreach workers and crisis counselors dedicated to the project. List separately if the provider has separate job titles for outreach workers and crisis counselors. In the fourth column, list any fiscal or administrative positions to be funded. In the fifth column, list the total number of full time equivalent (FTE) staff positions to be funded by the project. For additional information, see supplemental instructions on page 15.

[Insert text in table below. Insert additional rows or delete rows as necessary]

Agency	Supervisors/ Team Leaders (Number of Staff)	Outreach Workers/Crisis Counselors	Fiscal/ Administrative Staff	Total FTE
Agency Name	FTE	FTE	FTE	FTE

C. Organizational Structure. A simple organizational chart for the project is required for the Immediate Services application. An organizational chart may be inserted below, or a hand drawn chart may be attached to this document. Please indicate below if an organizational chart is attached.

[Insert text or organizational chart, or indicate that organizational chart is attached.]

D. Job Descriptions. In the space below, provide simple job descriptions (one paragraph) for each category of worker included in the project. (See page 16 of the supplemental instructions.) Optional job descriptions for the positions of Project Manager, Assistant Manager, Fiscal/Contracts Coordinator, and Crisis Counselors/Outreach Workers are available in the supplemental instructions and may be inserted here.

[Insert job descriptions here]

E. Brief Plan of Services. The types of services typically funded by the FEMA/CMHS Crisis Counseling Assistance and Training Program are outlined in the supplemental instructions (page 17) and in FEMA regulations and policies and in CMHS Program Guidance documents. In the space following, please provide a brief description of services to be provided. This description should include the following information:

- Types of services to be provided (e.g. individual outreach, crisis counseling, services to groups, public education, information and referral services);
- How staff will be deployed to provide these services
- Strategies for targeting those identified as in need of services, including special population groups identified in the needs assessment;
- Any quality control methods in place to assure appropriate services to disaster survivors; and
- Staff support mechanisms to be available.

For additional instructions on creating a plan of services, see pages 16-18 of the supplemental instructions.

[Insert service plan here.]

F. Training. Immediate Services Program grant funding may be used to support training within established FEMA training policies. Priority is placed on the use of trainers from within the State who have experience with the FEMA/CMHS Crisis Counseling Assistance and Training Program. Using the check-off boxes and narrative spaces below, please provide information on the trainers and proposed training content for the project. For additional instructions on training, see pages 19-20 of supplemental instructions.

1. Selection of Trainers:

- ❑ Our State has professionals experienced in the FEMA/CMHS Crisis Counseling Program who can provide training on the Crisis Counseling model. The names, resumes, and contact information for the trainers are provided with this application:

  [Insert trainers' names and contact information.]

- ❑ Our State is unable to identify an in-state resource for disaster mental health training. We request a referral for a crisis counseling trainer from CMHS/FEMA.

2. Training Content:

- ❑ Our State will be using the training outline provided in the FEMA/CMHS *Training Manual for Mental Health and Human Services Workers in Major Disasters, 2nd Edition.* Our State will be distributing FEMA/CMHS Program Guidance documents at the training.

- ❑ Our State will be using the attached training outline. (Attach the outline at the end of the application.)

3. Dates of Training:

Projected dates for training activities are listed below:

[Insert projected dates of training]

Part V. Budget

The budget must be integrated with the needs assessment and the program plan. The applicant may exhibit the budget in any format that is appropriate to the fiscal system of the State as long as the categories listed in the forms that follow are included. A separate budget must be provided for each service provider. There are three sections to the budget:

1. An overall summary of costs
2. Individual budgets for each service provider and the State Mental Health Authority
3. A narrative justification of costs

Note: Before completing any of the three budget forms, it is strongly recommended that applicants review the CMHS Program Guidance entitled Fiscal Guidelines for the Crisis Counseling Assistance and Training Program (CCP-PG-06). This guidance is included in the application package and is available at the CMHS website. In addition, CMHS has developed a Budget Estimating and Reporting Tool (BERT) that can assist in developing a budget within FEMA guidelines. This budget tool is available on the CMHS web page.

Additional information is provided in the supplemental guidance on pages 21-23. Sample formats are provided on the following pages.

Immediate Services Program
Summary of Costs for Entire Project

Disaster Declaration Number: FEMA-XXXX-DR-STATE

Budget Category	**State Budget: Total Estimate**	**Service Provider(s): Total Estimates*** *Note: attach Budget per service provider area	**Total Costs** of Immediate services. Add State and Service Provider total estimates.	**In-Kind Costs** Costs **contributed** to the project per agency.
Dates of Services				
Salaries and Wages Fringe Benefits (%) **Total Personnel Costs**				
Consultant Costs				
Office Supplies				
Travel				
Training				
Media/Public Information Costs				
Total Costs				

Immediate Services Program
Budget for State Mental Health Authority

Disaster Declaration Number: FEMA-XXXX-DR-STATE

Budget Category	**Interim Costs** Costs from the date of incident to the application deadline (14 days following the declaration)	**Projected Costs** Costs from the Immediate Services application deadline to 60 days or last day of program	**Total Costs** Add interim costs and projected costs	**In-Kind Costs** Costs **contributed** to the project per agency.
Dates of Services				
Salaries and Wages Fringe Benefits (%) **Total Personnel Costs**				
Consultant Costs				
Office Supplies				
Travel				
Training				
Media/Public Information Costs				
Total Costs				

*****The State Mental Health Authority and each local provider should fill out this budget form.

Immediate Services Program
Individual Service Provider Budgets

Name of Service Provider:

Budget Category	**Interim Costs** Costs from the date of incident to the application deadline (14 days following the declaration)	**Projected Costs** Costs from the Immediate Services application deadline to 60 days or last day of program	**Total Costs** Add interim costs and projected costs	**In-Kind Costs** Costs **contributed** to the project per agency.
Dates of Services				
Salaries and Wages Fringe Benefits (%) **Total Personnel Costs**				
Consultant Costs				
Supplies				
Travel				
Training				
Media/Public Information Costs				
Total Costs				

*****The State Mental Health Authority should work with each local service provider to develop budget and fill out this budget form.

Immediate Service Program
Budget Narrative

A budget narrative is required to document the types of expenditures included in the budget, justify the funding request, and demonstrate fiscal accountability. (See pages 21-23 of the supplemental instruction.) Please provide the following information:

1. How were salary levels and fringe benefits determined? Were they based on comparable positions in the local area? (If not, explain why.)

2. List all consultants, the services they will provide and their compensation.

Name of Consultant	Type of Service	Travel Costs	Compensation Costs

3. List the types of items listed under office supplies (i.e., cell phones, computers, and beepers, office supplies and maps). Detail on the number of items needed should correspond with the program plan.

4. List and describe the types of expenditures included in the travel category (i.e., mileage/rate, rental cars). Are the expenditures based on State rates for allowable travel costs? If not, explain and provide a justification.

5. List the trainers included in the training category.

Name of Trainer	Type of Training	Travel Costs	Compensation Costs

6. List and describe the types of expenditures included in the media/public information category.